MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

PLAN FIRST!

Family Planning Program Application

http://heathcare4mi.org

For questions and/or problems, or help to translate, call the Beneficiary Help Line at 1-800-642-3195 (TTY 1-866-501-5656).
Si necesita ayuda para traducir o entender este texto, por favor llame al telefono **1-800-642-3195** (TTY 1-866-501-5656)
Arabic: 1-800-642-3195 (TTY 1-866-501-5656)

إذا كان لديكم أيّ سؤال، يرجى الإتصال بخط المساعدة على الرقم المجاني ١-٨٠٠-٦٤٢-٣١٩٥

- ***PLAN FIRST!*** provides a family planning service benefit for non-pregnant women ages 19 through 44 who meet the conditions of participation listed below. The program does not cover any other health care services. For more information regarding ***PLAN FIRST!***, visit the MDCH website at www.michigan.gov/mdch. If you need more health care coverage than just family planning services (for yourself or other family members) contact your local Department of Human Services (DHS) office. To apply for more health care coverage, cash benefits, Food Assistance, Day Care or other services through DHS, go to www.michigan.gov/dhs for Assistance Application form (DHS-1171). If you have a young child(ren), you may also qualify for special nutritional assistance through the Women, Infants and Children (WIC) program. The toll-free number for WIC is 1-800-26-BIRTH.

PLEASE READ THE FOLLOWING CONDITIONS OF PARTICIPATION AND INSTRUCTIONS.

- I understand that this application is for one type of health benefit for services included in the ***PLAN FIRST!*** program, which is family planning services only.
- I understand that the ***PLAN FIRST!*** program does not cover primary care services for the treatment of any diseases or infections that may be identified during a family planning service visit. Your ***PLAN FIRST!*** family planning provider (e.g., local health department, physician, etc.) can inform you of how to access primary care services. Should you need further assistance with obtaining primary care services you can go to your nearest community health center or call 1-800-642-3195.
- I understand this program cannot provide coverage if I am already pregnant.
- I agree to the release of information from this application and supporting proof to evaluate and verify my eligibility for program participation. I understand that State agencies and their contractors involved in these eligibility verification activities will ensure confidentiality of my personal information in accordance with federal and state laws and regulations, including the Health Insurance Portability and Accountability Act (HIPAA) of 1996 and federal regulations at 42 CFR 431.300-431.307.
- I agree that my family planning service providers may release medical information related to services I have received to ***PLAN FIRST!*** program administrators. I understand that my service providers and the ***PLAN FIRST!*** program administrators will ensure confidentiality of my protected health information as required by federal law.
- I understand that if the State's ***PLAN FIRST!*** program pays for my family planning services and later identifies another party (such as private insurance) that should have paid for the services, the program has the right to recover costs from the responsible third party and to retain those funds.
- I understand that if I get more benefits than I am entitled to through my fault, I may have to repay any extra benefits received.
- I understand that I have the right to appeal a decision made by ***PLAN FIRST!*** program administrators related to my eligibility for participation or the scope of services that I am entitled to receive.
- I understand that the ***PLAN FIRST!*** program is a new program and is approved for up to five (5) years starting in July 2006.
- My signature certifies that I understand requirements related to enrollment in the ***PLAN FIRST!*** Family Planning Program.

INSTRUCTIONS FOR COMPLETING THE *PLAN FIRST!* APPLICATION

- **If you are pregnant, stop here. *PLAN FIRST!* does not provide services to pregnant women.**
- If the information is being provided by a guardian, answer the questions as the applicant would. The guardian will need to complete Section I-B.

SECTION I - A

- Enter full legal name: last name, first name and middle initial. Send a copy of your State of Michigan I.D., Driver's License, School I.D., or Passport)
- Enter your Social Security Number.
- Enter your date of birth.
- Enter home address, including street number, street name, apartment/lot number, rural route, city, county and zip code. If a different address is used for mailing purposes, include street number, street name, apartment/lot number, rural route, city, county, state and zip code. A post office box is not an acceptable address for either Home Address or Mailing Address.
- Enter the telephone number(s) where you can be reached.
- Answer "yes" or "no" if you are pregnant. (If yes, stop. ***Plan First!*** does not cover pregnant women. You may be eligible for Medicaid. Please contact your local DHS office for more information)
- Answer "yes" or "no" if you have received cash assistance or Low Income Family health insurance from the Department of Human Services (DHS) in the last four months.
- Answer "yes" or "no" to other health insurance or Medicare. If you or your spouse have other insurance, you will need to provide a copy of your card(s).

SECTION I - B (Guardian Information)

SECTION II

- Answer "yes" or "no" to your intent to remain in Michigan.
- Enter your primary language.
- Answer "yes" or "no" for citizenship status. If you are a citizen of the United States, you will need to send a copy of the document(s) that authorizes your legal status (e.g., birth certificate, passport, qualified alien documentation).
- Enter your racial/ethnic heritage. Information on racial heritage is voluntary and used for statistical purposes only.

SECTION III

This section asks questions specifically about your legal spouse and/or biological, adopted children, or stepchildren who live in the same house with you. If you are not married and/or do not have children, please go to Section IV.

- Answer "yes" or "no" to your marital status.
- Answer "yes" or "no" to if you and your spouse reside in the same household. If you and your spouse do not live together, do not complete the remaining information about your spouse. If yes, enter:
  - Your spouse's last name, first name and middle initial.
  - Your spouse's Social Security Number. This is optional.
  - Your spouse's date of birth (month, date and year).
- Enter information for each child (biological, adopted, stepchildren) that resides in the home with you.
  - Last name, first name and middle initial.
  - Date of birth (month, date and year).
  - The gender. ("M" for male and "F" for female).
  - Child's relationship to applicant and/or spouse .

SECTION IV

This section is about you and/or your spouse's source of income. **NOTE -** *Child care expenses can not be claimed if you pay your spouse or other parent of the child(ren) to watch the child(ren).

- If you and/or your spouse work and receive a paycheck, enter the amount you/your spouse receive before taxes, including tips, on the appropriate line.
- If you and/or your spouse are self-employed, provide the name of who is self-employed and the monthly income, minus allowable federal tax deductions.
- If you receive income that is not from a job, select the number from the list for the type(s) of income you and/or your spouse receive. Indicate who receives it, type of income, and monthly amount before taxes.
- Indicate how you support yourself and/or family without income.

SECTION V

- Enter the monthly amount you and/or your spouse pay for child support for a child(ren) outside of the home.
- Answer "yes" or "no" if you pay child care so that you and/or your spouse can work. NOTE: Child care cannot be claimed if you pay your spouse (or other parent of child) to watch the child(ren). The child(ren) must be under the age of 15 (or under 18 and need care due to a mental or physical limitation).
- Enter the monthly expense you and/or your spouse have for rental property that you and/or your spouse own. Enter the name of the owner(s) of the property.

SECTION VI

- Read the certification; sign and date your application.
- You will receive written notification of your application approval or denial from DHS.

NOTE - Processing time of your application will be reduced if you include the following with your application:

- Copy of the front and back of all health insurance cards (see Section I - A).
- Copy of your identification and citizenship verification (see Section I - A and Section II).

PLAN FIRST! Application

PLAN FIRST! does not provide services to pregnant women, but you may qualify for prenatal care through another program. See the program information in application instructions.

NOTE: You will need to prove your identity. Send a copy of your State of Michigan I.D., Driver's License, School I.D., or Passport.)

SECTION I - A (Applicant Information) -

Last Name: _____ **First Name:** _____ **Middle Initial:** _____

Social Security Number: _____ **Date of Birth:** _____ **Gender** ☐ Male ☐ Female
(month, day, year)

Home Address: (including apartment/lot number)

_____

_____

City County State Zip

Telephone Home:

(area code) _____

Mailing Address: (if different from home address)

_____

_____

City County State Zip

Telephone Other: (i.e., work, cell, relative and name)

(area code) _____

Are you pregnant? ☐ **YES** ☐ **NO**
(If yes, stop. ***Plan First!*** does not cover pregnant women. You may be eligible for Medicaid. Please contact your local DHS office for more information)

Are you currently covered by Medicaid? ☐ **YES** ☐ **NO**
If YES, what is your **mihealth** ID number?

_____

Have you received cash assistance (FIP or LIF) in the last four months? ☐ **YES** ☐ **NO**

Do you have other health insurance or Medicare?
☐ **YES** ☐ **NO**
If YES, send a copy of your health insurance card(s) (front and back)

SECTION I - B (Guardian Information) **Are you a court-appointed guardian for this applicant?** ☐ **YES** ☐ **NO**

Name: _____ **Telephone:** (area code) _____

Address: _____ **City, State, Zip** _____

SECTION II

Do you intend to stay in Michigan? ☐ **YES** ☐ **NO**

What is your primary language? _____

Are you a Citizen of the United States or qualified alien?

☐ **YES** - Send copy of proof of citizenship or alien status.

☐ **NO** - Stop you are not eligible for ***Plan First!***

What is your racial/ethnic heritage? (optional) _____ _____ (Choose letter from the following list.)

A-Asian or Pacific Islander, **B-**Black or African American (Non Hispanic), **E-**Other race or Ethnicity, **H-**Hispanic, **I**-Native American/ American Indian/Alaskan Native, **J**-Native Hawaiian, **O-**Caucasian / White (Non-Hispanic), **Z**-Mutually defined or multiracial

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SECTION III

SPOUSE AND/OR CHILDREN

Are you married? ☐ **YES** ☐ **NO** **Do you have any children?** ☐ **YES** ☐ **NO**

(If not married and/or do not have children, go to section IV.)

Does your spouse live with you? ☐ **YES** ☐ **NO**

Spouse Last Name: _____ **First Name:** _____ **Middle Initial:** ____

Social Security Number: _____ **Date of Birth:** _____
(optional) (month, day, year)

CHILDREN IN THE HOME ***(NOTE: Use a separate piece of paper if more space is needed)***

Last Name	**First Name**	**Middle Initial**	**Date of Birth** (month, day, year)	**Gender** (M/F)	**Relationship to Applicant and Spouse** (biological, adopted, and/or step child(ren))
					Applicant:
					Spouse:
					Applicant:
					Spouse:
					Applicant:
					Spouse:

SECTION IV

INCOME

Currently employed?	YES	NO	If YES, Monthly Gross Pay (before taxes)
Applicant	☐	☐	**$**_____ **/Month** (tips included)
Spouse	☐	☐	**$**_____ **/Month** (tips included)

SELF EMPLOYMENT

Name of Self-Employed Person	Monthly Gross Income, minus allowable Federal Tax Deduction (* Depreciation not allowed)
	$ _____ **/month**
	$ _____ **/month**

OTHER INCOME

List all other income received by you and/or your spouse.

1. Unemployment Benefits
2. RSDI (Soc. Sec. Benefits)
3. SSI (Supplemental Security Income)
4. Military Allotment
5. Veteran's Benefits
6. Retirement Benefits
7. Interest Income
8. Rental Income
9. Strike Benefits
10. Worker's Compensation
11. Employer Based Disability
12. Investment Income
13. Cash from Friends, Family
14. Other: Please specify_____

Name	Type of Income (number(s) from above list)	If RSDI Income, please enter Claim #	Monthly Gross Income (before taxes)
			$ _____ **/month**
			$ _____ **/month**
			$ _____ **/month**

NOTE: If you do not have any income, briefly explain below how you support yourself and your family.

_____

SECTION V

INCOME DEDUCTIONS

Monthly Child support you pay for children not living with you:		Do you pay any court-ordered guardian expenses?			Do you pay child day care * so you can work?			If you own rental property, provide expenses:
			Adult 1	Adult 2		Adult 1	Adult 2	$ _____ /month
Applicant	$ ____	**For Child 1**	**Y / N**	**Y / N**	**For Child 1**	**Y / N**	**Y / N**	**Do not complete this box unless you report rental income. These are your monthly expenses for rental property that you own and rent to others (not rent you pay). Name of rental property owner:**
Spouse	$ ____	**For Child 2**	**Y / N**	**Y / N**	**For Child 2**	**Y / N**	**Y / N**	
		For Child 3	**Y / N**	**Y / N**	**For Child 3**	**Y / N**	**Y / N**	

*** Child-care expenses cannot be claimed if you pay your spouse (or other parent of child) to watch the child. Also, the child must be under the age of 15 or under 18 and need care due to a mental or physical limitation.**

SECTION VI

CERTIFICATION AND SIGNATURE

I have read and understand the program requirements for this application. I certify under penalty of law that the information on this application is true, complete, and accurate to the best of my knowledge.

_____ _____

Signature (Applicant or Guardian) **Date**

Separate this sheet from instructions and return completed application and copies of required documents to:

***PLAN FIRST!* PO Box 30412, Lansing, MI 48909, or Fax to (517) 324-0710.**

http://heathcare4mi.org

Authority: Title XIX of the Social Security Act.
Completion: Completion of this form is required to enroll in the ***PLAN FIRST!*** Family Planning Program.
Penalty: Program enrollment will not occur without an application.

PLAN FIRST! Family Planning Program administrators and contractual staff will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, height, weight, marital status, disability, or political beliefs.